Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.07 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	9/22/2022

SUBJECT: Access Criteria for Drug Medi-Cal Organized Delivery System

PURPOSE:

To describe the County of Orange Drug Medi-Cal Organized Delivery System (DMC-ODS) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to DMC-ODS in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing DMC-ODS and Substance Use Disorder (SUD) services throughout Orange County.

REFERENCES:

Behavioral Health Information Notice (BHIN) 21-075 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

Behavioral Health Information Notice (BHIN) 21-071 Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

Welfare and Institutions Code § 14059.5

Title 42 of the United States Code § 1396d(r)(5)

DEFINITIONS:

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the DMC-ODS

A. For beneficiaries 21 years of age or older, DMC-ODS services shall be provided for beneficiaries who meet one of the following criteria in 1 and 2 below:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, OR

2. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

B. Narcotic Treatment Programs (NTPs) conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.

II. Criteria for Beneficiaries under Age 21 to Access the DMC-ODS

A. Beneficiaries under 21 years of age shall be provided all medically necessary DMC-ODS services required pursuant to Title 42 U.S.C.§1396d(r).

B. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.

C. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs.

D. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

III. Level of Care Determination

A. In addition to being medically necessary, all SUD treatment services provided to a DMC-ODS beneficiary must be clinically appropriate to address that beneficiary's presenting condition.

B. In accordance with Welfare and Institutions Code (WIC) §14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC beneficiaries.

1. However, a full assessment utilizing the ASAM criteria is not required for a DMC beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

C. For DMC-ODS beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a licensed professional of the healing arts (LPHA) or registered/certified counselor.

D. For DMC beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC-ODS beneficiary's first visit with an LPHA or registered/certified counselor.

E. If a DMC-ODS beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over.

1. The assessment time period re-sets in cases where the Episode of Care (EOC) has been closed, as open EOC must follow established timelines.

IV. Additional Coverage Requirements

A. Consistent with WIC §14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, and treatment services are covered and reimbursable Medi-Cal services even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC criteria are met, as described above.

a) Clinically appropriate and covered DMC-ODS services provided during the assessment process are covered and reimbursable even if the assessment later determines that the beneficiary does not meet criteria for DMC-ODS.

2. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

3. The beneficiary has a co-occurring mental health condition.

   a) Reimbursement for covered DMC-ODS services provided to a beneficiary who meets DMC-ODS criteria and has a co-occurring mental health condition shall not be denied as long as DMC-ODS criteria and requirements are met.

B. All Medi-Cal claims, including DMC-ODS claims, are required to include a CMS approved ICD-10 diagnosis code.